ONTARIO

PROVINCE OF ONTARIO

THE MEDICAL SERVICES INSURANCE ENQUIRY

Proceedings of the Public Hearings
held at the Galbraith Building,
University of Toronto,
Toronto, Ontario, at 10:00 a.m.
on Wednesday, January 8th, 1964. .

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THE COLLEGE OF OPTOMETRISTS OF ONTARIO

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Mr. M.A. Langer
Mr. I. Baker
Mr. E.P. Ashridge
Mr. J. Duffy
Mr. R.J. Broad

DR. J.W. McGILLIVRAY

MEMBERS OF ENQUIRY:

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Mrs. J.A. AYLEN

Mr. A. ROY COULTER

Dr. R. [illegible] HALLOWAY

Dr. JOHN HAMILTON

Mr. W.S. MAJOR

Miss HELEN McARTHUR

Mr. P.J. MULROONEY

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APPEARANCES: Mr. D.H.L. Lamont, Q.C.
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Mr. I. Baker
Mr. E. F. Attridge
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THE CHAIRMAN: Ladies and gentlemen, I assume this is the delegation of the Optometrical Association.

Have you read the instructions on the table before you?

Who is the spokesman who wishes to introduce your delegation?

MR. LAMONT: Mr. Chairman and ladies and gentlemen, may I say a word of introduction for our delegation representing the profession of optometry.

There are, as you know, two briefs filed. One from the Ontario Optometrical Association which is the voluntary body from Ontario and the practising optometrists, and the other brief is from the College of Optometrists of Ontario which is the governing discipline and qualifying body operating under The Optometry Act which statutes and regulations we go to the Minister of Health when amendments seem necessary. It is in the spirit of co-operation with other professions that these briefs have been prepared for your consideration.

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Basically, of course, the points of view in the two briefs are pretty similar and for that reason to assist this Committee in saving time the two groups are sitting at the table as one delegation to answer such questions as may be put to the groups if desired.

THE CHAIRMAN: I understand these will cover both briefs?

MR. LAMONT: One group representing the two briefs.

I think that no matter what is said this morning or what is said in the briefs, the most important point that we seek to make to the Committee is that we wish to assist the Committee in your considering the Bill from the point of view of the people of this province who may wish vision care as provided under the Bill and the best way of making that provision available no matter what is said. That is the main desire of our group, to assist your Committee in seeing what is the best way of providing care under the Bill, the services that are in the Bill.

The delegation is comprised of E. F. Attridge, in the center, who is the President of the College of Optometrists;

Mr. R. J. Broad, sitting at the end of the table, who is the President of the Ontario Optometrical Association;

Mr. Marvin Langer, to my immediate left, who is

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a practising optometrist in this city and is a member of the Social and Health Trends Committee of the Optometrical Association;

Mr. I. Baker, a member of the Board of the College of Optometrists;

And like myself a layman -- I am the lawyer of the Board -- Mr. James Duffy who is Managing Director of the Optometrical Association.

I think, if we may proceed with Mr. Attridge who has some preliminary remarks to make to your Committee.

MR. ATTRIDGE: Dr. Hagey, ladies and gentlemen of the Medical Services Insurance Enquiry, Ontario Optometrists believe the government is to be commended on Bill 163, insofar as its purpose is concerned.

However, as you will have gathered from our briefs, we have grave misgivings over certain aspects of this legislation.

Optometry's views concerning prepaid health programs, already stated publicly, are that today's needs can best be met by voluntary prepaid health programs available to all; comprehensive in coverage and utilizing the special talents, skill and training of health care professions whose members are licensed to practise. Our objections to Bill 163 lie its failure to utilize the various health care professions while including many of the services which they provide.

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while including many of the services which they provide.

In our view no government legislation, nor indeed any private development in health insurance programs, should be such that it can impede the orderly and necessary development of professions in the health care field. As such programs fall and mature they will themselves require increased numbers of all health care personnel to provide the benefits to an ever increasing population in this province. Yet one effect of Bill 163 is certainly to so impede the development of optometry to the detriment of the public.

To date only the medical profession and insurance carriers seem to have been directly involved in the proposed government legislation. Mr. Chairman, it would appear that Bill 163 is just what the doctor ordered. This has resulted, we believe, in an unduly restricted point of view which, in the long term, is likely to prove harmful both to the plan and the public which it is designed to serve.

Present insurance plans, and the proposed legislation, are generally referred to as providing "medical" services when, in fact, they include "health" services. Certainly, they include "optometric" or "vision care" services while excluding optometrists, who are by far the numerically larger group in this field and who provide the far greater proportion of vision care services, that is excluding the medical and surgical aspects of eye care. Curiously Bill 163 excludes optometrists thus aggravating a situation which is

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discriminatory in effect and completely impractical insofar as providing the services to a large percentage of the public is concerned.

Optometry is not advocating an extension of benefits under the Bill. Our point is that when optometric services are provided, then optometric practitioners must participate. We would be averse also to reducing any benefits and particularly those which help to improve the well-being of the people of this province.

Mr. Chairman, I would like to emphasize that it is not possible to disassociate vision care services from medical care or health care services, and if any of the members of the Enquiry would care to ask questions concerning this during the question period we would be pleased to discuss it.

Certainly it is not necessary to emphasize to the members of this Committee the important part which clear comfortable efficient vision plays in the lives of all age groups.

We speak of "vision care" benefits in Bill 163. By this we mean those procedures not excluded in Schedule A which optometrists are duly qualified to perform and which are also to be found in the Schedule of Fees of the Ontario Medical Association. Broadly speaking, this would include all optometrical diagnostic techniques and a number of treatment procedures.

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Refraction, perimetry and campimetry, tonometry and orthoptics are specified items in the Ontario Medical Association tariff which optometry by legal right and training provide their patients.

The majority of people requiring these services do obtain them from optometrists and it Bill 163 should go into effect in its present form these services would be unavailable to a large majority of those insured. And more particularly Bill 163 as it stands make provision for vision care of some 600,000 indigents who have no organized vision care program available to them today. Also there are another 600,000 who may be classed as semi-indigent who would benefit from these provisions. Optometry congratulates those who in, drafting this Bill, foresaw this unmet need in the field of vision care and provided for it. This is a very important aspect of Bill 163 but these citizens will not be able to receive this benefit unless the profession of optometry is included.

In the last few years we have heard a great deal about freedom of choice. Bill 163 would be a negation of the spirit and intent of this legislation if it could not provide complete freedom of choice of the legally and academically qualified professions. I noticed, Mr. Chairman, in the recent bulletin, that the Board of Trade of Metropolitan Toronto emphasized this point in their submission to this Enquiry.

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emphasized this point in their submission to this Enquiry.

We did not elaborate on the matter of cost in

either brief because, if the benefit is included, the cost ought not to be affected by the inclusion or exclusion of optometrists.

Actually, ladies and gentlemen, we think that the most serious defect from your consideration is that although it will appear to the public that vision care is provided for in the Bill the simple fact is that it will not be available though they will have paid for it. It is not my intention to use strong words but I feel I am forced to say that this would be deceiving the public. We do not believe that the government would have any part of such dealings.

The short-term and long-term effects upon the patient-optometrist relationship, the recruitment of future optometry students, the profession itself and the public welfare have been dealt with fully in our submissions to this Committee. We mention these only to remind the Committee of the far-reaching effects of Bill 163, or similar legislation.

We have made no attempt to discuss any details of Bill 163 other than its failure to recognize in principle and in fact, the need for optometric inclusion if the public is to be given the vision care which is required and provided by the Bill.

We believe that in the light of what has been said it is the responsibility of this Committee to deal with this matter. This is not a matter of administrative detail; it

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The short-term and long-term effects upon the patient-optometrist relationship, the recruitment of future

is one of principle, of equity and of the utmost importance to the public welfare.

If the broad general principles governing Bill 163 as enunciated by Premier Robarts and reported in the Toronto Daily Star on April 24th, 1963 are to be met and the purpose of Bill 163 is to be fulfilled then three things are required.

(1) Optometry, being the largest group in the vision care field and providing most of the services, which are provided for by the Bill, should be part of any group or groups studying this problem and future legislation that follows as a result of these hearings.

(2) That Bill 163 or its successor provide for the participation of optometrists in rendering all services included in such legislation, which they are duly qualified to perform.

(3) That, following the inception of such legislation, optometry be represented on its policy and administrative organization.

The College of Optometrists of Ontario and the Optometrical Association of Ontario believe most strongly that these are necessary and basic actions not only to fulfil the purpose of Bill 163 but also to assure that the people of this province receive now and will be assured in the future of the availability of vision care services of the highest order. It

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Mr. Chairman, we will be pleased to answer your questions. May I have your permission to direct these questions to the various members of our delegation in order that you may have the benefit of their accumulated experience.

THE CHAIRMAN: Thank you.

Miss McArthur?

MISS McARTHUR: I have a couple of questions.

The delegation, by your submissions, has recognized that there are other groups in the health profession that would be involved on the principles as enunciated in this brief of the Optometrical Association of Ontario and which you say it could not -- the total service could not be provided.

These other groups, such as being a nurse, particularly in a community where there is no medical profession available to the community, I am wondering if you thought through the question if it has to be this Bill, or this service has to be implemented in steps if priorities have to be established in relation to the kinds of services we require for a comprehensive service where you see eye care fitting into the total picture.

MR. BAKER: This, Miss McArthur, is an interesting question, and I don't know whether I can answer it specifically. The thing that concerns us is that in fact Bill 163 exists and

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MR. BAKER: This, Miss MacArthur, is an interesting question, and I don't know whether I can answer it specifically. The thing that concerns us is that in fact Bill 103 relates an

in fact vision care services are included in it. My understanding is that the reason that we are here is to discuss Bill 163.

Now, if in the government's wisdom they want to stagger the inclusion of various types of health care in some type of sequence, I think our profession would be very pleased to participate in such discussions. So, this type of staging, if proved to be useful and necessary and desirable, I think our profession would be prepared to discuss this and make its contribution.

However, I think the point here, and this is the point that concerns us, that in fact there is no provision of staging in this present Act. Optometric services are included in this Act. If this Act goes into effect as it now stands, that optometrists would be excluded from participating in it. We have maintained a position and I think we have made a fairly good argument, that this benefit cannot be given to the public generally under the present situation.

I think, in answer to your question, I would say this, that if there was an attempt at staging the development of health care services being made available to the public, I think yes our profession would be prepared to participate in such discussion and we have to stage it properly. I do not think this is the case in point at the moment.

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One of the problems here, and I think it will

constantly recur, is that it is very difficult to disassociate in any kind of staging, as I see it, diagnostic techniques. This, in effect is what this Bill offers to a very large extent -- is a series of tests of techniques by many practitioners in order to determine what the problem of that particular patient is. I am not too sure how simple it is. I have an idea it is complex to try to take out diagnostic technique 1, 2, 3, 4 and stage them in this way. I do not think it is that easy to isolate diagnostic techniques.

MISS McARTHUR: I have one other question.

I was wondering in those communities, and I notice in the brief there is a list of communities where there are optometrists and ophthalmologists.

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I was wondering in those communities, and I notice in the brief there is a list of communities where there are optometrists and opthalmologists. In those communities where there are both professions available to the community is there in any way, any joint planning in the eye care or occasions where the two groups work together as a team in giving services to the community?

MR. ATTRIDGE: I would say in many areas there is the finest co-operation. Just how close this co-operation is throughout the whole province, I can't say. I know there are many areas where the two groups practise that there is definite co-operation. I would say there is no special agreements. It is just co-operation.

MR. BROAD: There are other occasions, Miss McArthur. One instance is in the City of Hamilton where, I believe, the optometrists and opthalmologists work together on the school vision program. They work together.

MR. ATTRIDGE: They have for several years.

MISS McARTHUR: Is there any such thing as actual clinics, for instance, where the two work together?

MR. ATTRIDGE: Not to my knowledge.

MISS McARTHUR: I think those, at the moment are all the questions I have. I may have something later, sir.

THE CHAIRMAN: Thank you. Mr. Coulter.

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THE CHAIRMAN: Thank you. Mr. Coulter.

MR. COULTER: Mr. Chairman, and gentlemen I think firstly you should be complimented on both of your briefs. They are, I am sure, quite explanatory to people who understand medical terminology, but me being a layman, I would like you to explain it to me the terminplogy of refractions, the term "refraction", what does this really mean in layman's language? I hate to appear so dumb, but I would like it explained to me.

MR. ATTRIDGE: I think, perhaps, the simplest way of explaining it is to say that a person comes to the conclusion that certain symptoms, signs or obvious poor vision directed his attention to his eyes and he decides he has to go somewhere and find out whether or not, in fact, he has a problem. I think that one of the confusing things from our point of view is the word "refraction", as well. I think to try and explain it in the terms that I think you wish it to be explained, I think you would just go somewhere, to someone that you knew was qualified to do this and say I have this sequence of events occurring to me and what I want to know is do I have a problem, can I be helped, is this a medical problem or isn't it a medical problem and if so where should I go. All the procedures that a practitioner would carry out during this visit in order to determine whether or not the sequence of events which caused me to come to him, if the eyes were responsible for it and all the procedures, and there is a

MR. COULTER: Mr. Chairman, and gentlemen I think firstly you should be complimented on both of your like you to explain it to me the terminology of refractions, the term "refraction", what does this really mean in layman's language? I hate to appear so dumb, but I would like it explained to me.

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multiplicity of them, all of the procedures that would be carried out is generally referred to as a refraction.

MR. COULTER: Further to Miss McArthur's question in regards to medical people practising vision care or eye care in the Province there are few, really. With the number of people that have to have eye care or refractions, and if the Bill were left as it is where optometrists would be excluded, on referral how long would I have to wait, in your opinion, before I could get in to see a medical man to have my eye care?

MR. BROAD: Well, I believe at the present time this waiting period is anywhere from two to three months, and I think if you increase this work load by doing as you suggest, leaving the Bill as it is and sending all the refractions to the medical practitioner the waiting time would likely be increased greatly.

MR. BAKER: There would be one other side point I would like to add to that. There is a relatively long delay. The thing that one perhaps isn't aware of is that many, many people, and we as practising optometrists are very aware of this, many, many people do have these programs that exist now in this form, actually will not put up with this and will go outside of the plans at their own expense in order to get services that they feel they require now, so that the only reason -- though it is a relatively long period of time now it is not as long as it would be if everybody insisted on rates

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within the present plans that are in effect, because each one of us in his practice every day have a number of people from prepaid insurance plans which are in effect now, but they just disregard the benefit for which they paid in order to obtain services.

MR. COULTER: Are you saying there are some plans in effect today that people purchase either through group or else by purchasing it themselves on their own personal basis, they have refractions covered in their plan and when it comes down to the optometrist he doesn't have?

MR. LANGER: That is correct.

MR. ATTRIDGE: That is correct.

MR. COULTER: That is what happens today. In this case, if this happens I think you said that people then say well, I thought I had it covered, so do they then buy the glasses or have the refractions or do they go on out of your office and go on to somebody else that covers it?

MR. BAKER: No, they stay, most of them. As a matter of fact I shouldn't say they stay. They come in knowing they are not covered under the plans they purchased.

MR. LANGER: I would like to modify that a bit if I may. My own experience would be certainly not everybody is aware when they come into my office that they are not covered under the provisions of the plan. In fact, my impression would be quite the reverse, that the majority are not aware that the

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benefit is not available to them since they feel they have paid for the benefit and in many plans it is stated in terms something of this order: A refraction that is an examination for eye glasses is provided for as a benefit under this plan after a waiting period of one year. I find that many people do when they are informed that they are not covered, many people do feel since I have paid for this benefit I should get it and it would be foolish for me to pay a second time to you. Moreover as these plans have been in existence for many years we find that a number of our patients who may have perhaps decided on the first occasion that they would pay outside the plan subsequently feel, well, I have paid for this benefit and I should receive it and therefore choose another practitioner where the service is available. My feeling is the existing plans most seriously interfere with the choice of the practitioner on the part of the subscriber.

MR. ATTRIDGE: May I add to that as well, Mr. Chairman. We know that in 1961 there were 600,000 -- is that the correct figure -- examinations performed by optometrists in Ontario. We don't know the figure for 1962 at the moment, but 1961 would be a good example. Now, if you were going to add 600,000 more examinations to the medical refractionists who number less than one-third the number of optometrists in the province how can they cope with the situation in the first place. In the second place that would interfere, I feel, with their

part of the subscriber.

MR. ATTRIDGE: May I add to that as well, Mr. Chairman. We know that in 1961 there were 600,000 -- is that Ontario. We don't know the figure for 1962 at the moment, but

medical and surgical work which is vitally important and they are not the only people capable of taking care of eye glasses. There is no confusion there.

MR. COULTER: Just one more questions, Mr. Chairman. It may be a little bit below the belt, and if you don't wish to answer you don't have to. Due to the area of conflict, and I am not sure what is the reason for it within my own frame of mind here, what would be your opinion if vision care was deleted entirely from Bill 163?

MR. ATTRIDGE: Would you like to answer that, Mr. Langer?

MR. LANGER: You must consider one of the prime purposes of Bill 163 was to ensure that all people would be able to purchase comprehensive medical care plans, and to make provision for the indigent low income population receiving such coverage. Dr. Dymond has suggested some 1,200,000 people would require full or partial assistance in purchasing such a program, and if you look at Schedule C under the Act the proportion of older people in these groups of low income people is quite high, the very groups where requirements for vision care is the greatest. The present provisions in this province for providing vision care to this group is very minimal, while the Ontario Medical Welfare Plan makes, at least, some minimal provision for medical care for about 225,000 people, in contrast to this there has been direct provincial assistance to only an

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MR. COUTTER: Just one more question, Mr. Chairman, if I may. You don't wish to answer you don't have to. Due to the press of care was deleted entirely from Bill 163?

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estimated 2,600 people of the Province of Ontario each year for vision care. Obviously there is an urgent need for assistance to this category of people, and I would think that it would be a complete negation of the spirit and intent of the legislation to remove a benefit which has such wide application and for which there is such an urgent need, and furthermore I have grave doubts as to whether it is possible to exclude this profession. As has been mentioned ordinarily the average person that doesn't do what the definition of prepaid plans suggest, the average patient doesn't come to us to have his eyes examined to get glasses. They prefer we tell them it isn't necessary. They come with problems, with symptoms and they are interested in determining if these symptoms are ocular in nature and what needs to be done about them. If this Bill 163 makes provision for general medical services then it seems to me that these people would be qualified to visit a physician on that basis. I think Mr. Walpole of Windsor Medical has brought this to the attention of the Commission in an earlier submission when he pointed out that excluding the annual medical check-up it is very difficult in that people obtain it under another guise. I think exactly the same situation obtains here. The exclusion would have only one effect, it would exclude optometrists. It wouldn't exclude the patient, the subscribers obtaining the benefit. I believe there is some experience in this respect with present plans

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which exclude refraction for safety glasses. This is a very difficult if not impossible exclusion to make because if the patients present themselves for attention they are eligible for such attention under the plan. With all these considerations in mind I think the fact that the need is not met in present plans for the indigent and low income population, the fact that in fact to exclude the so-called refraction benefit is most difficult to do. I am not suggesting that the practitioner would practise fraud on the plan. I am just saying if the patient has a diagnostic service available from a physician he would then be eligible to receive these services if he presented his problem to the practitioner in the proper way. Therefore we would be most adverse from the standpoint of the welfare of the public to see such an exclusion take place. I think in the most recent review of ophthalmic services in England and Wales by Professor Almont Lindsay, who is a professor of history, he said that the overall figures with respect to the national health service left little doubt that despite the charges that were made for this service no branch of the Health Service was more widely and deeply appreciated than the opthalmic service. I think it would be impossible to make such an exclusion.

MR. COULTER: Thank you. That is all I have at the present time.

THE CHAIRMAN: Dr. Galloway.

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THE CHAIRMAN: Dr. Galloway.

DR. GALLOWAY: I have a few questions. I would like to explain to most of you although I hold a medical degree my knowledge of opthalmology is such I am sure you should consider me as a lay person. Any questions I ask will be taken on the basis I know very little about this subject. To clarify one thing for me, I understand the oculist is the medical man specializing in the practice of the eye. Optometrists you have well explained in your brief. What is the difference between an optometrist and an optician?

MR. ATTRIDGE: The optician doesn't examine the patient. He is the distributor. He fills the prescription that is written by the optometrist or opthalmologist.

DR. GALLOWAY: Do you as an optometrist refer patients to opticians or do you supply your own glasses?

MR. ATTRIDGE: We do both.

DR. GALLOWAY: What is the general practice?

MR. ATTRIDGE: Many patients prefer that we follow the case through and we engage laboratories to fill prescriptions and then we see the prescription is correctly filled and properly fitted to the patient. I must say that there is advantage in that procedure because when I examine a patient and write the prescription I see that prescription is correctly filled and correctly fitted to the patient. It gives me the opportunity to see the results of my work.

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me the opportunity to see the results of my work.

DR. GALLOWAY: In those cases in which you

yourself make the diagnosis for the need for glasses and you make the prescription and have it subsequently filled either by yourself or by an optician how do you regulate your charges?

MR. ATTRIDGE: All my charges are made on a fee for service, and when I use materials the materials are passed on to the patient at laboratory costs.

DR. GALLOWAY: Let me put this question in another way: Do you have two charges or one charge, one for the refraction and one for the buying of the glasses and fitting of them?

MR. ATTRIDGE: I have several charges. I have a fee for the examination and I have a fee for the work that has to be done in dispensing them. As far as the materials themselves are concerned the patient pays what I have paid the laboratory.

DR. GALLOWAY: What fees would the Medical Health Insurance Plan anticipate getting from the optometrists?

MR. ATTRIDGE: You mean....

DR. GALLOWAY: Of these three fees you have, that you charge to the patient, which of them would be held responsible?

MR. ATTRIDGE: The diagnostic fee.

DR. GALLOWAY: How much is that on an average?

MR. ATTRIDGE: $10.00.

DR. GALLOWAY: Is that a standard fee throughout

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MR. ATTRIDGE: The diagnostic fee.

DR. GALLOWAY: How much is that on an average?

DR. GALLOWAY: Is that a standard fee throughout

the province or is that your individual fee?

MR. ATTRIDGE: No, it is the Association Schedule of Fees.

DR. GALLOWAY: One sees as you are driving around, particularly in Toronto and listening to the radio a great number of advertisements, "Come in for free examinations, if you don't need glasses you will be told so and if you do then you will have them supplied to you". Are these services being carried on by optometrists or opticians and is it really a free service?

MR. ATTRIDGE: Well, I don't know where this line of questioning is leading.

DR. GALLOWAY: If you would like me to explain, I am trying to eventually determine how much money the basic plan in which we are interested in establishing is going to eventually have to pay.

MR. BAKER: Now, on that basis I would be very glad, Dr. Galloway, to answer specific questions. On this basis I think we could make this statement and I think we have indicated it in our submission, the College of Optometrists' submission, that in fact there are vision care benefits in the Bill. I think we would all agree about this. If they were academically based on the incidence of the anomalies of the population and the utilization rate of the population for that particular service then it really doesn't really matter who

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provides the service because it doesn't cost any more or any less to have one kind of practitioner to supply it or another kind of practitioner supply it. So in terms of the question as you put it to me now it really doesn't make any difference to the cost of the plan whether optometrists are included or excluded from it. The only variation could be that it would cost less if optometrists were excluded from the program simply because most people could not use it but if they could use it, as they could if the optometrists were included in the Bill, then the cost remains a static amount so that it does not influence the total cost of the service to the Bill if it has been provided for properly, actuarially.

To answer your other question, our profession is organized, like the dental and medical professions, and I presume the legal profession in a way in which there is a tariff or schedule of suggested fees to the practitioners. There are a multiplicity of services. Each one has had a dollar sign placed beside it. The Bill, as it stands now is primarily, not completely but primarily for diagnostic services, and there is no difficulty in establishing charges for them in this schedule because our fee schedule has been oriented in this direction for many many years. This is so.

The other aspect which you have brought up is certainly we have problems within our own profession. We have people who do not play the game the way we would like them to.

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I suspect that most groups have this problem. Ours may be a little bit more overt than other groups. Maybe that is a good thing because they can be easily identified but it is not a wrong conclusion to draw, or attempt to draw that the vast majority, 90% or even higher of the men in this field practise in a way which is in keeping with the objects and goals of our profession, and there is no problem.

On the other hand, just to make this clear, and this may be very useful in this regard, if a person knows that these services are paid for, I suspect that they will tend to choose their practitioner on the basis of his reputation and of his ability rather than on the fact that perhaps one place is somewhat less expensive than another so there may be, in fact, a very worthwhile side effect of this type of legislation and I think that everyone would agree that if services are paid for within a profession which still is highly competitive, as it has always been and this is a good thing, not a bad thing, people will tend to gravitate towards the better practitioner. From the public point of view this is a good thing. I have tried to answer your question Dr. Galloway.

DR. GALLOWAY: If I have by any chance given you the impression I have any disrespect for your profession, I certainly wish to correct that. There is no thought in my mind in that regard at all.

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what would be the major difference between what you do and what the opthalmologist does? Is there any major difference? In regard to fees I mean.

MR. BAKER: In regard to fees?

DR. GALLOWAY: What I am thinking about is fees and why is there a difference in fees if you are both accomplishing the same thing.

MR. BAKER: I don't know whether there is in fact a difference in fees sir. I am not aware that there is a marked or any discrepancy in fees.

DR. GALLOWAY: Would the two examinations then be comparable, one to the other?

MR. BAKER: In terms of fees?

DR. GALLOWAY: No, in terms of examination.

MR. BAKER: I think that in usefulness to a patient it would be my personal opinion, because you have to ask the opthalmologist his sir, but it would be my personal opinion that the public gets good and equal services.

DR. GALLOWAY: My final question: How much reference is there between the two professions? In your own practice, for example, would you refer ten, twenty, thirty, forty per cent?

MR. BAKER: I can answer that, if I may, Mr. Chairman as I was responsible for doing a study of our group over a period of years and that study was presented initially in

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Canadian Journal of Optometry and more latterly at the Royal Commission hearings. We found that in our survey between four and six per cent of the patients who presented themselves to optometrists were referred for medical consultation and that according to our studies, and the literature, both medical and optometrical, is about the incidence of ocular pathology in the general population.

DR. GALLOWAY: If the patient is referred by the opthalmologist to the optometrist for glasses, would the plan anticipate receiving an account from the optometrist?

MR. BAKER: No, I don't think the plan would anticipate because in fact those services which the optometrist would render, under those conditions, would not fall within the benefits being offered by the present Bill.

DR. GALLOWAY: Thank you very much.

THE CHAIRMAN: Mr. Whitney?

MR. WHITNEY: Mr. Chairman, this person called an optician, would you tell me more about an optician, giving me the distinction between the optician and the optometrist and tell me what the training is of the optician and the distinction from the training you have for the optometrist?

MR. BAKER: Well perhaps to just go back over the ground a bit and draw a parallel, the position of the optician in the opthalmolic field is very similar to the position of the pharmacist in the medical field. He is not an

DR. GALLOWAY: Thank you very much.

MR. WHITAKER: Mr. Chairman, this person called an optician, would you tell me more about an optician, giving

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MR. BAKER: Well perhaps to just go back over

initiator of services. He complies with the instructions of either the optometrist or the opthalmologist.

MR. WHITNEY: Is there any judgment in this regard so far as the training of the optician is concerned?

MR. BAKER: I am not sure of this. At one time, up to several years ago the optician was licensed under the Optometry Act and more recently, and I have forgotten the year but it is probably within the last three years, they have obtained their own statute and have set up their own training program.

When they were licensed under our Act, or controlled under our Act, the program, if my memory again serves me correctly, was an entrance requirement of Grade XII and I believe a year of training, or two years of training. Currently I have the impression that it is no more than that, and I would refer you directly to their licensing organization for more specific information but for the sake of trying to clarify this point here, I have the impression that it is now more or less on a home study apprenticeship type of training in this Province. Now specifically the duration of it, the ground covered, I am not sure but if my impression is correct, it tends to be on a home study apprenticeship type of program over a stated number of years.

MR. WHITNEY: Does the optician have the same right to offer his services in the market in the same way as the

either the optometrist or the ophthalmologist.

MR. WHITNEY: Is there any judgment in this

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of years.

MR. WHITNEY: Does the optician have the same

optometrist? To invite people to come into his office or establishment and does he use the same machines to test the eyes?

MR. BAKER: He does not do any testing at all, if I may use your terminology. The fact is that his work does not begin until either the optometrist or the ophthalmologist initiates it by direction.

MR. WHITNEY: So we don't find him with a store on the street and a sign hanging out inviting people to come in?

MR. BAKER: Yes, we do. As a matter of fact, I would say that the majority of their establishments are of this nature.

MR. WHITNEY: Well if one ---

MR. BAKER: Very similar to the pharmacist.

MR. WHITNEY: Well if we did go in to the optician, what would he do to us?

MR. BAKER: Well I think ---

MR. SIMON: Take your money for sure.

MR. BAKER: As a matter of fact, he might even give you some very good advice.

MR. WHITNEY: What services does he sell though. This is not a facetious question.

MR. BAKER: I recognize that. I think that what would occur is that if you walked in and said I think I have an

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This is not a facetious question.

MR. BAKER: I recognize that. I think that wha

eye problem, he would say that is too bad but I would suggest you either consult your optometrist or your ophthalmologist and then when he does what he has to do, you come back and see me. I would be glad to do what has to be done then, and he would fill the prescription, or if you walked in with a broken lens and said I am in trouble, I have to go out of town, he would replace this broken lens but if you went in specifically to have an operation on your eye, as such, I think he would refer you, and rightly so and I think he would be pleased to do that, he would refer you either to the optometrist or the ophthalmologist to seek that type of service.

MR. WHITNEY: He doesn't do testing to tell you whether you need reading glasses?

MR. BAKER: That is right; nor does he want to, I understand.

MR. WHITNEY: You mentioned that there are, or someone mentioned that there are 2,600 cases taken care of somehow on the welfare plan basis. Do you people have any sort of a welfare plan operating similar to the O.M.A. welfare plan to take care of those people who are under the seven welfare Acts that are listed in this Bill? I am thinking of the totally indigent group now.

MR. LANGER: There is no formalized procedure, no, such as the Ontario Medical Welfare Plan. Most of these 2,600 cases, that I referred to, would be cases where the

would fill the prescription, or if you walked in with a broken
lens and said I am in trouble, I have to go out of town, he
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Acts that are listed in this BILL? I am wondering of the
totally indigent group now.

MR. IANGER: There is no formalized procedure.

Province has decided, for individual reasons involved in the individual, that assistance must be given and they assisted the person in receiving care from a private practitioner.

There are some provisions municipally for such assistance in Ontario, service clubs and practitioners, many local societies, for example offer the service of their practitioners to various social welfare groups so that referral is made and provision of necessary services is given on a basis heavily subsidized by the profession. In many cases only the cost of materials would be charged, and in many cases even that charge would be waived but no formal provision, no.

MR. ATTRIDGE: May I add to that Mr. Chairman? Remember I mentioned in my remarks we are very pleased to see vision care has been included in Bill 163 in order that the people in this bracket will at least have the care that they deserve and require.

MR. WHITNEY: I am quite clear on that. Would you give me a little further explanation as to what the ophthalmologist does, that you do and don't do? What is the difference again in these services? I am not clear on that. For instance, does he do surgery of the eye?

MR. LAMONT: Yes.

MR. WHITNEY: He goes on into various things like that. Of course, you don't. You simply diagnose some sort of a, whether you call it occlusion or cloudiness, or something

that charge would be waived but no formal provision, no.

MR. ATTRIDGE: May I add to that Mr. Chairman?

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wrong in there, and you would send him then over for medical attention?

MR. LAMONT: Yes.

MR. ATTRIDGE: May I elaborate? The patient comes up to our office. The patient is examined. First the possibility of a pathological problem is definitely eliminated. If there is a sign that there is an incidence of pathology directly in the eye, or probably through the body, the patient is immediately referred to the proper practitioner. If it is in the eye, of course, it's to the ophthalmologist who is the man, and the only man capable of treating the medical aspects of the eye and also to perform all eye surgery. That is not our field. We do not want any confusion there whatsoever. We practise with the healthy eye. Once the fact that the eye is healthy has been established, then it is a matter of a motional problem; probably a matter of focussing of the eye, the co-ordination of the eyes. A matter of functional problem at any rate.

MR. WHITNEY: Where does the oculist fit into the picture?

MR. ATTRIDGE: The oculist and ophthalmologist are basically the same sir.

MR. BAKER: That is because most people cannot pronounce ophthalmologist.

MR. WHITNEY: That is a good reason. Now there

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MR. LAMONT: Yes.

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has been mention of present plans. The difficulty that you see in Bill 163, is that the difficulty you are finding in present plans as well?

MR. LANGER: Most assuredly, with the exception of course of those plans which make provision for inclusion of optometrists.

MR. WHITNEY: Now in the services you are suggesting be included here, does this include the furnishing of the eye glasses as well as the diagnostic treatment?

MR. ATTRIDGE: No.

MR. BAKER: I think that our spokesman has said sir that we are not advocating any increase in the number of benefits to be provided under the Bill. The fact of the matter is that those services, which are related to the dispensing of ophthalmolic material, and the actual cost of the ophthalmolic material -- eye glasses -- are very clearly excluded in the Act as it now stands. There is no confusion in our minds about this at all.

MR. WHITNEY: So the exluding of eye glasses up in Section 3 of the exceptions in the draft schedule is all right. This doesn't cause you the difficulty. This is number eleven is it, the refractions?

MR. BAKER: No. It's the whole Bill.

MR. WHITNEY: I think that is all I have Mr. Chairman.

MR. LANGER: Most assuredly, with the exception of optometrists.

MR. WHITNEY: Now in the services you are of the eye glasses as well as the diagnostic treatment?

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MR. WHITNEY: I think that is all I have Mr. Chairman.

THE CHAIRMAN: I would like to have further clarification on opticians. Are they licensed to perform refractions?

MR. BAKER: No.

THE CHAIRMAN: Therefore, if they do they would be doing an illegal act such as, for instance, a druggist if he diagnoses and prescribes would be doing?

MR. BAKER: He would run afoul of the Optometry Act and I don't know whether or not he might run afoul of the Medical Act as well.

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MRS. AYLEN: On refractions your definition of that is for diagnosis only. Would that include prescribing? There would be an additional charge for prescribing?

MR. ATTRIDGE: The total fee of diagnosis -- diagnosis and prescribing.

MRS. AYLEN: You stated that the regular cost scheduled fee is $10.00 for refraction.

MR. ATTRIDGE: Refraction and prescription.

MRS. AYLEN: Would the average person have more than one examination per year?

MR. ATTRIDGE: No.

MRS. AYLEN: So you could say one examination every two years for the average person?

MR. ATTRIDGE: I think our figures on service have shown that it is every thirty-four months.

MRS. AYLEN: So that the financial hardship involved for any person if refractions were removed, would that average to about $10.00 every thirty-six months?

MR. ATTRIDGE: Yes. We do not believe that you can disassociate refraction from other diagnostic services because, as has been stated, a person does not come and say I want a refraction because I want -- they still come with definite symptoms. For instance, supposing that a person were to attend one of the ophthalmologists and say, my eyes bother me in such and such a way. The only way we could find that out,

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as to what to do, is to perform a refraction and therefore you think you can ---

MRS. AYLEN: I am not putting the ophthalmologist versus the optometrist.

MR. ATTRIDGE: I understand.

MRS. AYLEN: I am just trying to find out what the financial burden to the average person would be if refraction were removed from the bill as being eligible under the Bill. It would represent a hardship on the average of not more than $10.00 every thirty-six months. Certainly not more than $10.00 a year. In other words, a person would not go for an examination more than once a year. So, that $10.00 a year per person would be about the financial hardship involved.

MR. BROAD: Where it would incur a hardship is for the one million two hundred thousand of low income.

MRS. AYLEN: Regardless of how many people, if you add that up in dollars for everything that benefits, it is a lot of money per person. Per person, it is a hardship of $10.00.

MR. BROAD: Yes.

MISS CARPENTER: If a person starts with an optometrist and from an optometrist goes to an ophthalmologist, the plan would pay for two fees -- the initial fee would be of the optometrist, and he says no it is not that you need glasses, it is the ophthalmologist that you must see. If that person

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goes on to an ophthalmologist, presumably there will be a second fee.

MR. BAKER: That is quite possible. The second fee would be for medical services, and in this respect it would not differ at all from the general medical practitioner referring a patient to a specialist after the patient has presented himself to the general practitioner. There is no difference in that relationship and in the relationship here either in the inter-practitioner relationship or the patient-practitioner relationship. It is not an unusual set-up in our scheme of things. I am now talking about the general health field. It does not create a peculiar situation.

THE CHAIRMAN: Dr. Butt?

DR. BUTT: I notice you were talking about the normal eye and also you talk about the diagnostic part of it. In other words, your eye care involved two aspects. And then you go on to campimetry. Could you give me an idea of what campimetry means with regards to diagnosis?

MR. BAKER: Campimetry is the investigation of the central field of vision. It is usually done on an instrument which is referred to as a tangent screen. A target is presented in the field of vision of each eye and the patient lets the practitioner know when he becomes aware of such a target. For this there are well known clinical standards.

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THE CHAIRMAN: Dr. Brett?

DR. BRETT: I notice you were talking about the normal eye and also you talk about the diagnostic part of it. In other words, your eye care involved two aspects. And then you go on to camptometry. Could you give me an idea of what camptometry means with regards to diagnosis?

MR. BAKER: Camptometry is the investigation of the central field of vision. It is usually done on an instrument which is referred to as a tangent screen. A target is presented in the field or vision of each eye and the patient lets the practitioner know when he becomes aware of such a target. For this there are well known clinical standards. In other words, the findings are well known as

what the normal is. What the optometrist is interested in is, does this patient respond to this test in a normal fashion. If he reacts to the test in an abnormal fashion, that is, the findings are not what the standards are, this simply means there is something wrong and the optometrist then refers him to the ophthalmologist who makes the diagnosis. It is a screening which is used -- the same technique as to whether that particular person and that particular eye responds in a normal manner.

DR. BUTT: What does tonometry mean?

MR. BAKER: The measurement of inter-ocular pressure.

DR. BUTT: Both these would have certain pathological findings if abnormal?

MR. BAKER: That is right. Just a matter of taking a scale reading. The standard is more or less established of what is considered to be a normal finding in the average eye. If the finding varies from this again, it is indicative that further investigation should be done.

DR. BUTT: To do all this, I believe, a tonometry would be taken, is this correct?

MR. BAKER: Yes.

DR. BUTT: What do you have to do to take the pressure -- put drops in the eye?

MR. BAKER: There are two ways of doing it. One

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MR. BAKER: There are two ways of doing it. O

is a newer development and will probably supersede the older one. A tonometry can be done on the sclera by using a standard schiotzometer, to use it on the sclera rather than on the cornea. When you use it on the sclera it can be used without any topical anaesthetic.

Newer development in that field has been prevented by massive costs and we are beginning to see a breaking through of the electronic tonometer, and it is being applied to the cornea without anaesthetic.

It is a matter of time until science catches up with us and gives us another newer and better method.

DR. BUTT: This is all what you feel is diagnostic services?

MR. BAKER: Yes, and we do it.

DR. BUTT: Refraction is merely getting glasses to suit the particular eye?

MR. BAKER: Refraction is again actually a sequence of events, if I may just expand on it, in which we are investigating the optical, the motor and sensory function of the eyes.

The most commonly known to people is either far or short-sighted astigmatism and presbyopia. This is what refraction means.

It really does not mean this in this field nor the field of ophthalmology. It is a sequence of tests that

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actually establish the pattern of binocular and monocular vision and bases its investigations on the optical, the motor and the sensory aspects of vision.

DR. BUTT: You do not use any drugs at all in order to take your tonometry?

MR. BAKER: That is right.

DR. BUTT: One other thing that I was wondering about a little bit and maybe you can tell me. It is 26 of your Effect of Bill 163 on Student Recruitment.

"If, as a result of legislation, too few students are available or the quality of applicants lowered, how will the Government justify the part which its decisions have played in the loss of service to the public."

Can you give me any idea of the number of optometrists there were ten years ago and now in Ontario?

MR. BAKER: We have a Royal Commission brief. I would say there are approximately the same. There is not a wide variation.

DR. BUTT: Would you disagree with me when I say I have for 1956 665 and for the present time 548. Is that wrong?

MR. LANGER: Yes. I have 165 at no time.

DR. BUTT: I said 665.

MR. BAKER: That may be right.

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DR. BUTT: Those are correct?

MR. BAKER: Yes.

DR. BUTT: As far as students are concerned in the United States, in 1951 there were 2,015 registered, and in 1961 1,422. In other words, to be quite frank I do not feel that this Bill as such would indicate recruitments of students.

MR. LANGER: Perhaps I could explain the figures you are quoting. The 1951 figures represent an enormous influx of post-war students. Therefore, you will find that the average number of students at that time was considerably higher than in 1960.

Now we find the situation, our experience at the College of Optometry that the curve following the period of 1947 to 1952, let us say, at which time we would have perhaps three times the ordinary number of students in our classes.

Immediately following that period, there is a drop, in effect, of what perhaps existed. There is somewhat of an over supply; and the curve now is reversed and is passing into the same situation on all professions -- there are numerous students knocking at the door and our facilities are inadequate to train the number who come to us.

We have indicated before to the Royal Commission that our needs with respect to students would double by 1980, and our present facilities would not permit us to meet those needs.

MR. MUTT: Those are correct?

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I think our point here is obviously if there are factors operating in the field of practice which inhibits patients visiting optometrists, this is going to make the field less attractive to qualify students.

DR. BUTT: These factors have happened. You can explain them as a scholastic situation.

When you get the Tables, I think there are ophthalmologists doing refractions, and then quote a figure of 224 as of November 1963 which I believe disagrees with your figures.

MR. LANGER: I believe our figures were obtained from the College of Physicians and Surgeons.

DR. BUTT: Those were certified?

MR. LANGER: Those were certified ophthalmologists

DR. BUTT: Those are different from those who are doing refractions?

MR. LANGER: This is difficult to establish.

DR. BUTT: There are these other figures, in all fairness should be taken into consideration because they have been trained and perhaps not completed their five-year post-graduate work to obtain their certificate as such.

MR. LANGER: We did try to establish a figure to include that. Our Table I believe, as the Table the Association has presented, has tried to indicate certified and non-certified.

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THE CHAIRMAN: Mr. Major.

MR. MAJOR: Gentlemen, I would like to take a little different approach on this and as a citizen determine what my position is. I'd like to start off this way, that as a citizen if I attend an optometrist for a refraction or eye examination, would it be reasonable for me to expect with that examination to give me the full picture of my eye condition? Is it possible that through drugs or psychoplegics you can determine pathological conditions that cannot be determined without them?

MR. BAKER: I think you have two questions there. The answer to the first question is, yes.

The answer to the second question is that so far as we are concerned and so far as any studies that have been made, there is no great disadvantage in terms of spotting the abnormal from the normal -- of spotting the abnormal and normal without the use of drugs. I think the very fact that optometry exists on the strength it does that it is a world-wide profession that is licensed to practise in this field all over testifies to the fact that the public is well protected in this and there is an area of responsibility and competence as has been demonstrated over the years.

The pattern is well set so far as North America is concerned and Great Britain. If you go to the United Kingdom

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you will find under the National Health Scheme there that optometrists by far do the largest proportion of the work -- somewhere between 80 and 85% of the total of the work in this field.

MR. MAJOR: That is less than one available for 100,000 people in the United Kingdom?

MR. BAKER: I do not know what the reason is. I can tell you what is happening.

This development has taken place -- I am talking about academics and not utilization in Australia and New Zealand and so forth. I want to get it out of the context that may be implied here, not suggesting what you are implying can be misinterpreted -- it is a rather local situation. Optometry exists all over. It is there and it has been for many years. I think all I can say to you is when we developed the scheme in the Royal Commission, it was because this kind of question was asked. There is very little doubt of the optometrist's ability to carry out this responsibility.

I think that our present relationship with ophthalmologists indicate that this actually operates. There is no problem, I am sure. We make a number of mistakes but I think they are legitimate mistakes. The fact of the matter is that by and large there is no problem here. There is no necessity for any reticence on the part of anyone.

MR. MAJOR: Supposing, and I am not a doctor nor

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MR. MAJOR: Supposing, and I am not a doctor

am I an optometrist but I am in the business of medical insurance and this is the way we think in terms of living -- supposing that a citizen has an eye examination by an optometrist and that examination missed some stomach or metabolic condition, would the optometrist have any legal responsibility?

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[redacted]

MR. BAKER: In this province I believe the answer would be no.

MR. MAJOR: He wouldn't. I think that came to mind because of the ratio of ophthalmologists, if my memory serves me right, I believe the World Health Organization set up standards attempting to arrive at the standard of ophthalmologists, I am talking about certificated medical practitioners per one hundred thousand population. In the United States I think that figure ran three ophthalmologists. In the United States that figure runs about 3.3, and I am quoting from memory again, in Ontario the figure runs approximately two, between 2.5 and 2.6, so that I am tempted to question this so-called lack of ophthalmological services to the public. It may be a matter of getting it properly spread around geographically.

MR. BAKER: Is that a question?

MR. MAJOR: No, I am speaking of a fact. We have heard of this lack. You stated two or three times that there wasn't enough ophthalmologists to do the job. We are very close according to the World Health Organization standards. How fast we will need them, that I don't know.

MR. LANGER: Could I comment on that?

MR. MAJOR: Sure thing.

MR. LANGER: I believe that first of all there are a number of figures that are of interest here. That is the

MR. BAKER: In this province I believe the answer would be no.

MR. MAJOR: He wouldn't. I think that came to

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MR. LANGER: Could I comment on that?

MR. MAJOR: Sure thing.

MR. LANGER: I believe that first of all there

figures that are available indicate utilization of vision care services in Canada of approximately 13.2% of the population per year. As I understand the utilization figures from programs such as Windsor Medical and P.S.I, the utilization of vision care services under these programs is about 6%, between five and six per cent.

MR. MAJOR: That would be approximately right. It wouldn't be more than six.

MR. LANGER: It seems to me with these programs, eye vision care is exclusively provided by ophthalmologists and I think a subscriber that is covered for this service presumably will utilize it. The fact that the utilization under this program is considerably less than the utilization of the general population indicates the ophthalmologist is unable to provide the service to all that require it. Certainly with respect to geographical distribution I don't think it could be disputed that it is impossible for ophthalmologists to provide services. I don't think we are suggesting there is a shortage of ophthalmologists but we are suggesting that vision care services which is optometrical requires an optometrist to perform. This is perhaps the different attitude between our attitude and your attitude.

MR. MAJOR: Have optometrists thought of developing any travelling clinics? In other words optometrists are not in every geographical area of the province. Is there

five and six per cent.

MR. MAJOR: . That would be approximately right.

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attitude and your attitude.

MR. MAJOR: Have optometrists thought of

any thought of taking these people in there on a travelling clinic basis?

MR. LANGER: There is a great deal of that in existence at the present time where a practitioner might, perhaps, arrange to have a clinic in the community one day a week or a month in order to provide services to an area which isn't serviced by a practitioner.

MR. MAJOR: The ophthalmologists are doing the same thing?

MR. LANGER: I believe the ophthalmologists are doing the same thing.

MR. MAJOR: There is a strong attempt being made by both professions to cover these so-called non-covered districts through travelling clinics.

MR. BAKER: There is also recognition of this in the Junior Red Cross. They have a vision care program and it is staffed by optometrists who cover the north country during the school season.

MR. MAJOR: Tell me, do you put much value in the Snellon Test?

MR. BAKER: If you could explain to me what you mean by that?

MR. MAJOR: The Snellon Test is some kind of chart whereby you determine whether any person, child or adult, particularly a teenager rather than a small child, can read

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the Snellon Test?

MR. BAKER: If you could explain to me what you

mean by that?

MR. MAJOR: The Snellon Test is some kind of

certain classifications of letters?

MR. BAKER: Yes. Trying to answer the question in this context, it is probably the best single test for screening, the best single test, but it has inherent in it two problems, it both under and over refers. I am not sure of my statistics on this, but they are significant. There has been enough work done in this field in terms of screening where it has been proven beyond any doubt at all that total reliance on this test is not particularly desired.

MR. MAJOR: It will give you a signal as to the next milestone?

MR. BAKER: It gives you part of the signal but it can also mask a problem. It both under and over refers. The biggest problem is one of under-referrment. All vision problems are not related to visual acuity at that distance.

MR. MAJOR: In other words use of this kind of test in outlying districts is questionable but it could be handled by the general practitioner in medicine?

MR. BAKER: Well, it is, isn't it?

MR. MAJOR: Not necessarily.

MR. BAKER: I think I am trying to interpret what you are pointing to is that in fact someone else could detect this problem.

MR. MAJOR: Up to a point.

MR. BAKER: That is the direction of the question?

MR. BAKER: Yes. Trying to answer the question

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MR. MAJOR: That is right. What I am endeavouring to do is to come to this, it is pretty nigh impossible to provide professional people, and I am going to talk about medical people around the province, neurologists, ophthalmologists, the specialist, the highly trained specialist with twelve or thirteen years behind them of training and it has become the order of the day or is becoming the order of the day to have set up travelling clinics or bring these people to the centre. What we really need in these districts is a reasonable screening process to get them here; isn't that right?

MR. BAKER: Well, with all due respect we are talking here about two things. First of all if you got the trained manpower, and you will concede optometrists are trained manpower why single them out, why not include them. This only makes the problem more serious, no matter what side of the fence you want to sit on. I think the remarks I made to Miss McArthur apply here. We are talking about Bill 163 and we are talking about the benefits that are in Bill 163. It seems to me and this is one of the things that we pointed out, and perhaps didn't express too clearly in our Toronto Optometrists' brief, we are talking here of what we consider to be at least a social change in which third party groups now come into health care and you are representing one of these third party groups. What we are saying is that you have, and I don't mean you as an individual, the third party groups have a responsibility in the

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field because health care in this province has developed a certain pattern. It may not be the best pattern, but it has developed a certain pattern which has met many of the needs that the public have. What this has done, and P.S.I. has contributed to this so far as this field is concerned is that in offering a refraction benefit in these contracts, which particularly in some of the areas it has sold, it can't possibly fulfil its obligation. All I am saying here and I think this is the pertinent thing in terms of Bill 163 is that in these very places where these services are being sold and not available under that contract the fact is there are optometrists and the public has to make a choice of either going outside their program and paying for these services themselves, but if they have already paid in your contract they wait for somebody to get an automobile or a van and come from where they live to another centre in order to obtain the services of the program. The fact is that this thing operates. There are optometrists that look after the bulk of the vision care services and talking of the World Health Organization, I am not familiar with their figures, but I think it is medically orientated on the number of ophthalmologists required to look after the medical and surgical needs of this public rather than the vision care needs because that is their emphasis, and I think they would agree with this. The fact of the matter is that the whole world is flooded with statistics.

We know how many people seek these services and we know that optometrists serve most of us. I think we must go on the basis of what exists. There is no need for theorizing on this.

MR. MAJOR: P.S.I. sales contract, the legal contract?

MR. BAKER: Right.

MR. MAJOR: Bill 163 is determined to become a legal contract. As Bill 163 is presently set up this contract covers services of licensed medical practitioners known as physicians. This is the fundamental point here. If you bring into this Bill that you have now discussed all the health services that should be brought in whether they are diagnostic or not, where do you place the optometrist in respect to the oral surgeon and the podiatrist and nurses. If I was in bed with a case of pneumonia do I want to have sitting beside me a nurse or an optometrist?

MR. BAKER: I would choose a nurse.

MR. MAJOR: What we are talking about is not relevant in the wording of this Bill because this Bill is a physician service.

MR. BAKER: No.

MR. MAJOR: It has nothing to do with optometry, nothing to do with podiatry, nothing to do with dentistry, it has nothing to do with nursing.

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MR. MARKER: No.

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MR. BAKER: Right.

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into this Bill that you have now discussed all the health

THE CHAIRMAN: It is not entitled that way. It is the Medical Services Insurance Act. It doesn't say physician service.

MR. MAJOR: Then it is necessary to define a physician.

MR. SIMON: It is not yet defined. That is why we are here.

MR. WHITNEY: To be fair, Mr. Major is referring to the Bill as it now stands. This doesn't say the Bill as it now stands is going to be the final form recommended by this Enquiry. I don't think we should spend any more time on these areas.

MR. MAJOR: If we are going to recommend on an undiscriminatory basis to include diagnostic services of the paramedical people being qualified by training or by inference that they may help out the situation by diagnostic services, then we have to include a lot more than the optometrical profession.

MR. WHITNEY: That is our problem.

MR. MAJOR: If you find an optometrist who is not practising according to your standard of ethics can you cancel the licence or commission or whatever it is? Have you power to control this man?

MR. BAKER: Yes.

MR. MAJOR: Do you do it?

THE CHAIRMAN: It is not omitted that way. It

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MR. MAJOR: Do you do it?

MR. BAKER: Yes.

MR. MAJOR: During the questions you stated that if you sent a patient, if you decided a patient should go to an ophthalmologist it would take from two to three months for this patient to get to the ophthalmologist?

MR. BAKER: That is not correct, sir.

MR. MAJOR: Did I misinterpret it?

MR. BAKER: I don't know whether you misinterpreted it but I can certainly clarify it. The question I was asked was how busy were the ophthalmologists, and that was the answer. The fact of the matter, though, is the relationship between the optometrist and the ophthalmologist. It is such that we generally will say to a patient we think that you need medical consultation. Generally speaking the patient will say who should I go to, that is pretty typical to the health care field. You may tell them one or two or three names of ophthalmologists and they will say this one is in my district, can we see him. Generally it is a matter of picking up the telephone then and speaking to Doctor So-And-So and saying, Doctor, I have a suspicion of this, and he will say I will see him tomorrow. There is no problem.

MR. MAJOR: That is what I wanted. I see the examination fee, $10.00. You talk about special procedures, tenometry and something else. Is this included in your $10.00 fee or is it straight refraction and so on?

MR. BAKER: Yes.

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examination fee, $10.00. You talk about special procedures,

fee or is it straight refraction and so on?

MR. BAKER: It is generally included.

MR. MAJOR: It includes all the special things, refraction -- your eye examination is a wrap-up?

MR. BROAD: We consider it.

MR. MAJOR: In the milestones of examination as you go along these would also be included?

MR. BROAD: Yes.

MR. MAJOR: You say you have a fee schedule. Would it be possible for your organization to forward to the Chairman of this Enquiry a copy of that fee schedule with the procedures that you feel should be covered in Bill 163 identified.

MR. DUFFY: Yes.

MR. MAJOR: Because we will be likely studying that question.

MR. LANGER: Sir, there is one point here, and this is, of course, we don't to restrict or to have the appearance of restricting the service. Our basic contention is made on principle, any service we are legally and academically qualified to perform which are provided for in Bill 163 should be available from optometrists, and therefore we wouldn't wish to be in the position of having a type of particular procedure.

MR. MAJOR: It is only incidental to help us. The same procedure has been put before this Enquiry by the oral surgeons and podiatrists, exactly the same thing. Mr.

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Chairman, I think that answers my questions.

THE CHAIRMAN: Mr. Naylor.

MR. NAYLOR: In answer to Mr. Coulter's question you stated some very good argument against omitting eye refractions from the Bill. However, on the other hand there are some things I have been wondering, looking at the Bill from an insurance point of view, whether the expense of refractions should be included. For one thing as Dr. Hagey brought out the financial hardship arising from this expense is not too great on any one person. A further point is that I believe that this service is to some extent elective, at least the frequency of its use is elective. Would you agree with that? Would you agree that there would probably be increased usage on this if it were insured? Have you any suggestions? Do you feel that limitations to help control this would be desirable? Have you any suggestions as to what limitations might be appropriate?

MR. BAKER: If I may be permitted to begin answering the question. The experience, the only experience I can go to is the question of controls and abuses by either the practitioner or the public. The fact of the matter is that when the benefit is set on the program for a good deal of time, and the only reference I have for making this statement is the National Health Services, the fact is that it has flattened out and stayed, the utilization rate has stayed somewhere around 13%.

THE CHAIRMAN: Mr. Naylor.

MR. NAYLOR: In answer to Mr. Coulter's questio

appropriate?

MR. BAKER: If I may be permitted to begin

There was an upper rate, and that was several years ago, about two years, if my memory serves me correctly. The greatest rate I believe they have hit was 20% utilization and it dropped back. Incidentally, there, you know they supply everything, everything in the way of ophthalmic material. The experience there indicates that particular benefit is not abused generally. There is a pattern. It has been going for years and running somewhere around 13%. There is one peaking and that was it.

So far as the procedure, it is partly elective. It is not always elective, and I say that because in my practice, for example, there is hardly a day or a week that goes by that little Johnny or Jane doesn't come in with a slip from the school nurse saying he can't or she can't see the black-board, and in this sense it is not elective. Once the treatment is begun to a large extent it does become elective, there is no doubt about that, so there are many aspects to it. I think that the feeling of the group, and I stand to be corrected by my group, is that on the average the routine check-up can be properly limited to once every two years.

There might be special cases, but they tend to be the exception rather than the rule and whether or not they can be handled, I think this is a matter of conference and discussion as this comes in. Of course, as you know, any one of our recommendations - the only way to get many of these problems, technical problems smoothed out, administrative

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of our recommendations - the only way to get many of these

problems smoothed out is actually bringing in the groups that are involved and sit down. We hope we are reasonable people and there is no reason why these things can't be worked out. I don't know all the controls. I am sure that controls are available against abuses and all the other things. I cannot add any more to my remarks.

MR. LEMONT: I would like to pursue this, if I may. First of all, this question of being elective, I should like to point out is true of many many services that are covered under the Medical Services Act and, therefore, I do not think is germane to single out vision care service as being something different.

Many services are elective and you might, therefore, argue could be left out. Similarly, many services involve a small expense to the individual that could be left out. Surely what we are talking about here today is not catastrophic insurance but comprehensive coverage.

On that basis it seems to me the public has demonstrated, quite conclusively, that this is what they are seeking: Comprehensive services which would involve first call visit, from first visit and all aspects of services that are required.

Now even with respect to this question of small financial burden, I can tell you certainly from personal experience in my office that while that figure of $10 does not

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Now even with respect to this question of small financial burden, I can tell you certainly from personal

represent a considerable burden to the average person, certainly for the group, particulary I can think of old age pensioners, many old age pensioners have made statements in my office to the effect that well do I have to come back for a second visit? That means an extra car ticket and so this matter of expense is relative, certainly, and I think it is not inconsiderable to many people because, particularly with respect to the old age pensioners the incidence and utilization of this group would be high, and of course, similarly the family group in which a number of members of the family require eye care the cumulative cost could represent a substantial proportion of the health care budget for that family, so I think it is a mistake to single out vision care service as being something different from the other services which are covered in the program.

I think that we naturally think of the large expense involved in long, serious illnesses but most of the coverage provided under this plan is for services of exactly the same nature which may be elective and have a small cost for the individual.

MR. MAJOR: May I follow this up in this manner---

THE CHAIRMAN: Were you finished Mr. Naylor?

MR. NAYLOR: Not actually. I was just going to complete this particular point. I think you have answered the question very fully. Do I take it then that if it were

the effect that well do I have to come back for a second visit? That means an extra car ticket and so this matter of expense is relative, certainly, and I think it is not inconsiderable to many people because, particularly with respect to the old age pensioners the incidence and utilization of this group would be high, and of course, similarly the family group in which a number of members of the family require eye care the cumulative cost could represent a substantial proportion of the health care budget for that family, so I think it is a mistake to single out vision care service as being something different from the other services which are covered in the program.

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MR. MACDONALD: May I follow this up in this manner

THE CHAIRMAN: Were you finished Mr. Naylor?

MR. NAYLOR: Not actually. I was just going to question very fully. Do I take it then that if it were

considered that this should be included that some limitation should be put on it? Perhaps an appropriate limitation might be one every twenty-four months.

MR. BAKER: Yes.

MR. NAYLOR: That is fine.

THE CHAIRMAN: Mr. Major?

MR. MAJOR: Following through your thinking sir, as a citizen would you rather have a comprehensive health service with the $50.00 deductible against it to start something off, or would you rather have this health coverage on a limited basis to start it off?

THE CHAIRMAN: You can only answer this as a personal opinion rather than as an opinion from your Association.

MR. MAJOR: I asked him as a citizen.

THE CHAIRMAN: If you wish to answer it.

MR. ATTRIDGE: I think that would require considerable thought. I wouldn't want to answer that on a snap judgment.

THE CHAIRMAN: Any further questions? Mr. Simon?

MR. SIMON: If the demand on the part of the public for vision care has increased in recent years, and whether the fact of more and more people living in urban areas, under the stress and emotion of modern day living, television and so on, have you studied any effect of this increased demand?

MR. BAKER: I think this has had this effect sir:

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MR. SIMON: If the demand on the part of the

MR. BAKER: I think this has had this effect a

One requires a much more effective visual system to operate in our society today successfully, and to compete successfully. I don't think this caused any problems, but if it has done so a lot of them have been masked simply because the demand has never been placed on the individual. When you consider our whole way of life, you barrel along the highway with a ton of steel under you, and have to read signs at a long distance, this is a far cry from the fellow who used to go along with his horse and cart and had all day to decide what to do. So in this sense certainly the importance of vision to the person in order to live and stay alive and compete in our society is much greater now.

I see it in my own family where I have two youngsters in public school in the early grades, and they have been forced to, because they don't do it voluntarily, they have been forced to read more books than I did in all the time I was in public school, so that constantly the demand is growing, and then for entertainment they watch T.V. all evening so that the fact of the matter is you are right. I agree and this is why we feel it is so important for them, for the children's well-being and more importantly to compete in our society even has become an extremely important sense.

THE CHAIRMAN: Mr. Caswell?

MR. CASWELL: There is just one question I would like to ask, and I am sure there is an answer to it. It

MR. CASWELL: There is just one question I

does affect me just a little bit. You stated that an optician formerly had Grade XII and then one year training course and now he is trained, more or less, by correspondence and yet he is the man, I take it from you who in many many cases is the one who actually produces the glasses that you prescribe.

Now it seemed to me that this is terrifically important. That once the prescription has been made that it should be a very qualified person who fills this prescription. I am sure there is an answer but I am wondering with the limited amount of training evidently this optician has, how are we satisfied that we are getting the correct glasses?

MR. BAKER: I think that I added something here. First of all, I feel it was Grade XII and two years training, just to get the record straight. I think so. So far as training is concerned this would be a question which you should direct to the optician because he is much more familiar than I about training policy. One thing else that is involved, so far as the public is concerned and that is that it really is the ophthalmologist and the optometrist who assumes the responsibility that this is a correct device.

In our own office, whether we carry out the treatment service or have the treatment service provided by someone else, the patient comes back and is checked up. I believe that this is the custom of many ophthalmologists, so that in the last analysis the responsibility lies with the

MR. BAKER: I think that I added something here just to get the record straight. I think so. So far as

as the public is concerned and that is that it really is the

In our own office, whether we carry out the

prescriber.

MR. CASWELL: As you have said, the customer can still go in off the street to the optician and select a pair of glasses which he would put on and which he might read with very well at the moment.

THE CHAIRMAN: I don't think that is correct.

MR. BAKER: No.

MR. CASWELL: They do not sell to the customer?

MR. BAKER: No.

MR. BROAD: He will replace a broken lens sir. If you had a broken lens and went into his office, he could duplicate the broken lens or would phone the ophthalmologist or optometrist and get the prescription and fill it from that.

MR. CASWELL: You couldn't go in and buy a pair of glasses?

MR. BROAD: No.

THE CHAIRMAN: You used to be able to go into Woolworth's and buy glasses. What would prevent -- this is really aside from the issue here. This is more for my personal information, this question, than anything else but what would prevent an optician from selling glasses to a person who came in and decided what he wanted, just the same as the majority do in Woolworth's?

MR. BAKER: I think the answer to that is they are responsible people. They have integrity and they operate in

MR. CASWELL: As you have said, the customer

with very well at the moment.

THE CHAIRMAN: I don't think that is correct.

MR. BAKER: No.

MR. CASWELL: They do not sell to the customer?

MR. BAKER: No.

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do in Woolworth's?

MR. BAKER: I think the answer to that is they

a manner that most people would expect them to.

THE CHAIRMAN: This is a little more serious question. Assuming that an individual may go over to an ophthalmologist -- this is not an ophthalmologist versus an optometrist -- for refraction diagnosis that is included in the Act now, as far as the ophthalmologist or oculist is concerned, he could do that every year but we do not permit, under the Act as it is drawn up now, an annual or periodical health examination. Would you say that you could reconcile these two factors?

MR. BAKER: I am not sure that I understand this completely sir. Just let me ramble for a moment. I am not sure that we have any information as to the frequency at which refraction benefits may be utilized under this present Bill.

2 THE CHAIRMAN: As I interpreted the Bill there is no limitation. Is that right Mr. Whitney? In other words under the present Bill as it is drafted, an individual could go to an ophthalmologist for an eye examination every six months and he would still be eligible.

MR. WHITNEY: So far as I read it I think that is correct.

THE CHAIRMAN: Now can you reconcile the two? That we do not permit under the Bill as it is drafted here, an annual or periodical health examination.

MR. BAKER: I can only make an assumption Dr.

a chance that most people would object than to.

THE CHAIRMAN: This is a little more serious question. Assuming that an individual may go over to an optometrist -- this is not an ophthalmologist versus an optometrist -- for refractive diagnosis that is included in the Act now, as far as the ophthalmologist or oculist is concerned, he could do that every year but we do not permit, under the Act as it is drawn up now, an annual or periodical examination. Would you say that you could reconcile these two factors?

MR. BAKER: I am not sure that I understand this completely sir. Last year we spoke for a number. I am not sure just we have any information as to the frequency at which refractive benefits may be claimed under this present Bill.

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MR. WHITNEY: So far as I read it I think that is correct.

THE CHAIRMAN: Now can you reconcile the two?

MR. BAKER: I can only make an assumption Dr.

Hagey here. I would have imagined that that particular matter would have been taken care of under the regulations in the sense of how frequently a particular benefit might be utilized. As I say, I was impressed with the -- I read the transcript of the hearing at Windsor, and I was impressed with this gentleman's statement when you have a first call involved, which you apparently do under this Bill, how you are going to distinguish between that and annual inspection. This struck me as being a very difficult thing.

MR. WHITNEY: That is a real problem.

THE CHAIRMAN: If refractions are permitted to remain in the Bill, and again regardless of whether this is done by an ophthalmologist or an optometrist, would it be just as logical that there be a limitation put on it?

MR. ATTRIDGE: Yes.

THE CHAIRMAN: What limitation would you suggest?

MR. ATTRIDGE: Two years.

THE CHAIRMAN: Every two years?

MR. ATTRIDGE: Yes.

THE CHAIRMAN: I assume that the cost of the glasses, aside from the examination for them, is approximately the same regardless of whether they are prescribed by an optometrist or an ophthalmologist. Is that correct?

MR. ATTRIDGE: There should not be any difference.

THE CHAIRMAN: Not any wide variation?

MR. WHITNEY: That is a real problem.

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THE CHAIRMAN: What limitation would you suggest

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THE CHAIRMAN: Not any wide variations?

MR. ATTRIDGE: The laboratory costs plus the extra services that are entailed.

THE CHAIRMAN: What would be your opinion as to the average cost of a pair of glasses? Now I realize that they can vary. From how much to how much?

MR. ATTRIDGE: Such a great variation depending on what is involved. It reminds me of someone said how many prescriptions can you write and I just read an article recently where it indicated, it showed figures that there is something more than two or three trillion. Of course, you see that involves a great deal of variation in the expense and again if a person wants to use them, can use a very cheap, a very inexpensive frame or they can, if they want, go into an elaborate frame.

THE CHAIRMAN: I am thinking primarily of a person who has difficulty in financing the cost of glasses. So assuming that this individual would be inclined to use the most economical frame available, would the average cost for the glasses be in the neighbourhood of $12.00? $20.00?

MR. ATTRIDGE: I am not hedging but are you talking about single vision? Are you talking about bifocles? Are you talking about trifocles?

THE CHAIRMAN: I am trying to strike an average across the board. I will tell you exactly what I am leading up to in this question. I am not trying to catch you on anything.

MR. ATTRIDGE: The laboratory costs plus the extra services that are entailed.

THE CHAIRMAN: What would be your opinion as to can vary. From how much to how much?

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MR. ATTRIDGE: I am not hedging but are you talking about trifocals?

MR. ATTRIDGE: No, I know.

THE CHAIRMAN: And that is that in my humble opinion the hardship involved for the individual is not the original $10.00. Am I right in that?

MR. BAKER: Part of it.

THE CHAIRMAN: The cost of the glasses is a greater financial hardship than the cost of the examination.

MR. ATTRIDGE: It depends. I do not think it should be in most cases. Now admittedly you won't get much lab work done for $10.00.

THE CHAIRMAN: That is what I mean.

MR. ATTRIDGE: It would be more than $10.00 in most cases.

THE CHAIRMAN: I do not recall getting a pair of glasses myself, even right from the very beginning for less than $10.00.

MR. ATTRIDGE: It would be, in most cases, more than $10.00.

MR. BAKER: I think this opens up a whole area for discussion. Doesn't the same attitude prevail here in terms of saying well if you are going to provide medical service, which this Bill does, it really doesn't provide any treatment service, other than the surgical ones, and it seems to me that one could carry this same argument along and say well what has cost more, the medical service or the pharmaceutical devices

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MR. LAKE: I think this opens up a whole area...

that are required in order to treat it. It's in the same realm.

THE CHAIRMAN: I am not debating the issue. I am looking for information for the record. Are there any other questions?

MRS. AYLEN: I have one very short one. Does your profession take part in any research projects in relation to diseases of the eye or eye problems shall I say?

MR. BAKER: If you mean by "our profession" the profession generally, the answer is very definitely yes. Most of our research in this field has been done in the United States and is being done in the United States and most of it is being done in the University Schools in the United States and they have been involved very deeply with the Armed Forces, and so forth, and their grants are quite astronomical. We have done some limited research at our own College here. We are doing more and if we can find the answer to finances, we will do even more but generally speaking optometry has made a very significant contribution to ophthalmolic literature here and in the United Kingdom and so forth, Australia.

MRS. AYLEN: Do you ever take part in any out-patient clinics in the hospitals?

MR. BAKER: We would like to. I think the answer to that is that we would like to. There is some activity but it is limited. We would like to do more. We do operate a clinic here, you know. It is not a joint clinic at all.

in the United Kingdom and so forth, Australia.

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patient clinics in the hospitals?

MR. BAKER: We would like to. I think the answ

THE CHAIRMAN: Any further questions?

MR. MAJOR: I wonder if I could clarify one point that keeps coming back to my mind and that is this 2,600 people that were handled. 2,600 indigents. Was that on a special arrangement?

MR. LANGER: This is not any special arrangement at all sir. The 2,600 indigents that I referred to are the numbers, the approximately numbers in any given year who received direct Provincial assistance and obtained vision care. I cannot tell you any breakdown as to who was provided care, but this is the number that the Department of Welfare has indicated to us.

MR. MAJOR: I understand. In other words, this is not 2,600 persons treated by optometrists or ophthalmologists. This is the whole works?

MR. LANGER: Yes.

MR. MAJOR: In other words, does this intimate that the 230,000 people on the medical welfare plan do not get eye care except on a special arrangement of either one or the other?

MR. LANGER: That is correct.

THE CHAIRMAN: Do you have any further statements Mr. Attridge?

MR. ATTRIDGE: Yes. I think Mr. Broad has a statement.

MR. MAJOR: I wonder if I could clarify one

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THE CHAIRMAN: Do you have any further observa

MR. BROAD: Dr. Hagey, ladies and gentlemen, if I may be permitted with your permission to make a closing statement, I would like to thank you very much for your questions and I hope that you understand that we answered them with sincerity and as factually as we possibly could.

However, the problem, as we see it, Bill 163 does violate what we consider to be certain basic principles. First: That legally qualified optometrists are excluded from performing vision service included in Bill 163. And secondly, the right of the public to free choice of practitioner has been denied. Thirdly, there has been no discussion with the optometrical profession whose service forms a part of the enactment of this nature. There is, we feel, a simple way of resolving this problem: Include optometry the way division services are included in the Act and permit us to assist in preparing that portion of the Act where our services are designated.

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T/hm

MR. BROAD: May we take this opportunity of impressing on you again the sincerity of our presentation and let me assure this Committee that the Ontario Optometric Association and the College of Optometrists have a sincere desire to co-operate with the Committee, the government and any or all professions in the health care field in order that the people of Ontario may receive the finest form of health care service.

Our offices are at your disposal to assist you in any way we possibly can. We are aware, as all must be, of the magnitude of your task before you. We wish you well in your deliberations. We are certain that this Committee will arrive at a final recommendation that will be acceptable to all and in the best interest of the people of the Province of Ontario.

Thank you, ladies and gentlemen.

MR. MULROONEY: I think these gentlemen should be commended for their presentation of the case.

DR. BUTT: In view of your final statement, I believe you have carried on some negotiations with co-ops.

MR. BROAD: Yes.

DR. BUTT: We would be most interested in receiving from you all the details of this which might be further useful to us.

MR. BROAD: We will certainly see that you get it.

MR. BROAD: May we take this opportunity of

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SUBMISSION OF

DR. J. W. McGILLIVRAY

THE CHAIRMAN: I assume you are Dr. McGillivray?

DR. McGILLIVRAY: Yes.

THE CHAIRMAN: Did you read the statement of instructions? If not, we will allow you to read it.

DR. McGILLIVRAY: I have.

THE CHAIRMAN: Do you wish to proceed?

DR. McGILLIVRAY: Mr. Chairman, I made suggestion of this presentation not as a representative of any organization but representing certain ideas which are old ideas held by many people, many of them dead, perhaps most of them dead now. That is the idea that the individual of this society is fully capable of making his own decisions rather than having his decision of health matters made for him in such a role with such a group of people.

Would you like me to read my short submission?

THE CHAIRMAN: As stated in the instruction, the members of the Enquiry have read your brief. You can emphasize any part of it or supplement what you wish. I hope you will not attempt to read the whole book.

DR. McGILLIVRAY: I will not. I think I would prefer -- I have certain ideas which may be perhaps better shown up if there are any questions which you would consider.

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DR. McGILLIVRAY: I will not. I think I would

If there are no questions, then of course you do not wish to consider my idea at all.

Basically my idea is, if poor people need money they should be given money; and they are fully capable of voting and fully capable of fighting and dying for their country and fully capable of drinking beer in a beer parlour or buying liquor in a liquor store and capable of spending their own money for health insurance if given the opportunity.

Some of them, if they have no money, may need money. This is something that the government should decide, that the poor who need money should be given money.

As my Appendix A states, this may be made exceedingly easy for them to buy health insurance if they wish. The net result of putting the money in the hands of the people, and I am not a supporter of the Social Credit Party, is that the people can decide what type of insurance they wish.

We have just heard that the optometrists wish to be included. Oral surgeons also wish to be included. The chiropractor also. As you will see in my paragraph 5 sub-paragraph 5, and as I noted in the press, the Christian Scientists feel they were paying tax to support a medical system in which they do not believe. I submit this is unfair, taxing the Christian Scientists to support another church in which they do not believe.

If the oral surgeons and chiropractors and

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If the oral surgeons and chiropractors and

physiotherapists wish to be included in this, the government I suspect cannot afford to pay for it. If they go before a limited group that Bill 163 is supposed to cover and if my suspicion and many other people's suspicions prove correct, this is going to be extended to include the whole population.

Then the government is going to either legislate in or legislate out certain groups. In other words, they will water the pot plant of organized medicine and they will leave the pot plant of optometrists, chiropractors, Christian Science, oral surgeons, to go dry, because the government is the largest controller of the funds which would come into these various places, health professions if you care to use that term.

I would honestly think there may be some poor people who are poor and who might not buy health insurance. We should accept the fact that they should be given the opportunity to buy it as they see fit. If they see fit not to buy it, this is their responsibility. They probably think they do not need it.

I would hope that the Committee would not feel that the government had to mind everybody's business and compel all the poor people of the province to have the type of plan the Committee thinks is best. I see no other way around this except start letting these poor people buy what they wish.

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THE CHAIRMAN: I hope you gathered from the

instructions that it is not the intention of the Enquiry to debate any issues.

We do ask questions where we feel there is need for clarification. I think that your point is a very simple and forward point.

Are there any members of the Enquiry who have questions to ask?

MRS. AYLEN: I notice you are Dr. J. W. McGillivray? What are you a doctor of?

DR. McGILLIVRAY: I am a practising surgeon.

MRS. AYLEN: In what town?

DR. McGILLIVRAY: Collingwood.

MRS. AYLEN: You say you think the people should be given the money to spend as they see fit. Do you have any reason to believe they would spend it on paying doctor bills as opposed to buying a case of beer?

DR. McGILLIVRAY: I knew someone would raise that question and I am glad you did.

If they would rather buy a case of beer with their five dollars a month, it is because they do not particularly want medical insurance. If this is so, then I submit it is beyond the proper limits of the government to insist they have medical insurance. The reason they would be given this money is according to the philosophy that gathers momentum behind the medical push. These people -- social justice demands

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that they be given more money or they are receiving insufficient of society's goods and services.

If they buy a case of beer, they apparently do not wish to have medical insurance which means less push for medical insurance.

MRS. AYLEN: Is it fair to ask you, do you have any bills you cannot collect?

DR. McGILLIVRAY: Yes, quite a few.

MRS. AYLEN: You do not mind that?

DR. McGILLIVRAY: I like to collect them.

MRS. AYLEN: You would just as soon they buy a case of beer?

DR. McGILLIVRAY: No, buy insurance. If they cannot be free to spend their social justice money, then neither can I.

MRS. AYLEN: The expression "second-class citizens" seems to be coming up quite often. What is your definition of a second-class citizen?

DR. McGILLIVRAY: The rules of this Enquiry are that there shall be no second-class citizens which means it is assumed that there are in Ontario no second-class citizens, which means the poor who want medical insurance would buy medical insurance if they had the money is what I am suggesting.

THE CHAIRMAN: Are there any other members who wish to ask questions?

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wish to ask questions?

MR. CASWELL: Should they not be given $10.00 a month so they can buy both beer and insurance?

DR. McGILLIVRAY: With the rate of taxation, if they spend it on hard liquor it would cost us dollars worth of taxes.

MR. WHITNEY: This freedom of social justice money, tell me where it comes from and what it means.

DR. McGILLIVRAY: It is the composite poor, the idea that our poor are poor through no fault of their own but because they have been a victim of misfortune or ill done by by a sharp business man, and from the rest of society they need help and that help has taken the form of family allowance and old age pension, and now it is being suggested that it take the form of the medical care insurance act. We do not give them food and clothing. We give old age pensioners, we give them money and I am suggesting we pay them approximately $75.00 a month for the amount for their insurance money for the year -- their thirteenth month if you like. This is what I mean by social justice. It is a Robin Hood system which has apparently been accepted.

MR. WHITNEY: The essence of your suggestion is that you are suggesting to the Enquiry that we consider in our recommendations to the government that government tax everyone in Ontario, gather into the fund this taxation money and then send out cheques?

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MR. WHITNEY: The essence of your suggestion is that you are suggesting to the Inquiry that we consider in our

send out cheques?

DR. McGILLIVRAY: This is certainly what I am suggesting.

MR. WHITNEY: I think that is all I have, Mr. Chairman.

THE CHAIRMAN: Mr. Naylor?

MR. NAYLOR: This is a very interesting proposal and personally I am all in favour of your idea of having large freedom of choice for the individual as possible and as little government compulsion as possible.

There is one point that possibly should be qualified. Your brief suggests your plan to help involves the government purchasing, making the government the largest single purchaser of insurance in the province. That is not what is proposed.

What is proposed is that individuals may purchase insurance and if they do and if they are in a certain income category the government will help them to pay premiums. There is no compulsion of paying insurance. So that the difference between your idea and the idea of the Bill seems to be merely that the person is not given the financial assistance unless he actually decides to buy insurance.

DR. McGILLIVRAY: He can take it or leave it.

MR. NAYLOR: That is right.

DR. McGILLIVRAY: Can take what the government thinks is good for him or he can have nothing at all.

DR. McGILLIVRAY: That is certainly what I am suggesting.

MR. WHITNEY: I think that is all I have, Mr. Chairman.

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DR. McGILLIVRAY: He can take it or leave it.

MR. NAYLOR: That is right.

DR. McGILLIVRAY: Can take what the government thinks is good for him or he can have nothing at all.

MR. NAYLOR: No. This plan, standard plan as it might be called, that is laid down by the Bill is to be made available. Carriers can and will offer other kinds of insurance with lesser or greater benefits.

DR. McGILLIVRAY: And totally subsidized, and they will be able to choose which carrier and which type of plan they wish.

MR. NAYLOR: No. Subsidy will only be available on the standard plan, and that is the point.

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on the standard plan, and that is the point.

MR. NAYLOR: You still think that additional staff is desirable to give responsibility, to give the lower income classes the money regardless of whether they buy insurance or not?

DR. McGILLIVRAY: If the concept underlying this is the concept of social justice and if these people are competent to vote then I would suggest they are competent to decide what insurance they want. They'd get further in debt if they had a fire or automobile accident. That is certainly a very big point, an automobile accident without automobile insurance, I mean collision insurance as well as liability insurance. He could be far more financially crippled by lacking one of these other insurances than lacking medical insurance. It might be that the individual thinking citizen would be buyer or not, would be better off to buy a different kind of insurance or simply buy clothes for his children, put shoes on their feet. He may be perfectly happy living in Toronto getting his optometrical from the Optometry College which I did when I was a student, his dental from the College of Dentistry, which I did as a student and his medical from the health services or the out-patient departments, from the out-patient departments of the Western Hospital, Sick Children's. He might be better off to do that and spend his money on his rent.

MR. NAYLOR: Suppose he lives in Collingwood and

MR. MAYLOR: Suppose he lives in Coalingwood a

did when I was a student, his dental from the College of Dentistry, which I did as a student and his medical from the

MR. MAYLOR: You still think that additional

gets money from the government and decides not to buy the insurance hoping he will be lucky and not have any heavy expense. If he does have heavy medical expenses he would have to go to a doctor such as yourself for it.

DR. McGILLIVRAY: Yes.

MR. NAYLOR: Wouldn't you recommend he had the insurance?

DR. McGILLIVRAY: I would be sorry if he didn't.

MR. NAYLOR: You would still be willing to provide the service?

DR. McGILLIVRAY: The most crippling expense, heavy medical expense, would still be the hospital bills. We still have patients that don't have hospital insurance. I don't send a bill. If they haven't got enough money to buy hospital insurance there is no money left for me and I don't worry about it. I wouldn't like that to get around.

MR. SIMON: You are unique.

DR. McGILLIVRAY: Sir, I think there are a lot like me. You can't get blood out of a stone. For the people without insurance you don't waste your stamps trying to collect the money.

MR. SIMON: Wouldn't you rather see they did have insurance?

DR. McGILLIVRAY: That would be fine. There is the other thing, that is if they are going to be compelled to

to go to a doctor such as yourself for it.

DR. McGILLIVRAY: Yes.

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have insurance, the long and short of it is that the medical fees and the optometrist fees and the dental fees and the pharmacist fees, once these are included, assuming that it is, they will be compelled by the government which may have a deadening effect. That is the reason why I would rather do without the odd money from my poor indigent patients and maintain my control and theirs.

MR. CASWELL: Some people have to be taken care of, they always have and they always will and this is one way of doing it.

DR. McGILLIVRAY: The profession, if I may speak briefly of the profession, has always looked after these people and will always care for them. They cared for them before there was any medical insurance at all. I am not suggesting they wouldn't get medical care. I am suggesting we would all be better off if we weren't compelled to have medical insurance under the government's terms.

MR. CASWELL: Is there a reasonable reason why one group of citizens in the province should carry this responsibility? You are suggesting it is the responsibility of the medical association to take care of this. The government would suggest it is the responsibility of all the citizens of the Province of Ontario.

DR. McGILLIVRAY: If I may, Mr. Chairman, I should say the medical profession has never objected to this

REPORTING DIRECTORATE
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of the Province of Ontario.

DR. MacGILLIVRAY: If I may, Mr. Chairman, I

responsibility. Objections have come from social workers and various other people who want to do good for the poor people. The doctors have never objected to this as a group, and very few of them individually. I should suggest that the doctors are willing to have this medical insurance grow as it grows, but the government would be taking a hand, a controlling hand.

THE CHAIRMAN: Dr. Galloway.

DR. GALLOWAY: My question has already been asked and answered.

THE CHAIRMAN: Any further questions?

MR. SIMON: If we draw the conclusion to the logical end the government should not interfere with parents having three children, eight, ten and twelve, not sending them to school but sending them to work. Is that all right with you?

DR. McGILLIVRAY: I haven't entered into the education problem at all.

MR. SIMON: It is the same thing. If the citizen is made to choose whether he is going to have insurance he is going to send his children to school or send them to work -- he is choosing a lot of things. Is there to be no government intervention?

DR. McGILLIVRAY: May I take this further: Supposing you follow this further and people who have medical insurance that have to have an operation, have to have an

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DR. McGILLIVRAY: May I take this further:

operation or blood transfusion. Are you going to compel them to do that because a legally qualified medical practitioner says you must have this operation? Is Government going to take that responsibility for an adult, not just for children? When you are compelled to have medical insurance should you be compelled to accept the medical treatment that is advised to you because a qualified person is telling you?

MR. SIMON: Bill 163 doesn't say anybody is compelled to have medical care. The government will pay for people that want insurance and can't afford to pay for it themselves. There is a difference in that.

THE CHAIRMAN: I think, Dr. McGillivray, you are presenting a philosophy almost of life here, which is a temptation to debate. I think some of the members of the Enquiry are yielding to that temptation. I must admit I am having trouble not doing it myself, but that isn't our job here today. It is a temptation, I'll grant you that. I don't think we should yield to that temptation here any more than we have with other delegations we have heard. We do want to ask questions and seek for clarification and I don't want to stop that at all.

DR. BUTT: Could I add one thing. I took the liberty of asking a question yesterday of a social worker and I have a quote from her. I asked her about your proposition and she said that I would certainly think social workers would

to you because a qualified person is telling you?

MR. SIMON: Bill 163 doesn't say anybody is compelled to have medical care. The government will pay for people that want insurance and can't afford to pay for it themselves. There is a difference in that.

THE CHAIRMAN: I think, Dr. McGillivray, you started a philosophy discussion here, which is a temptation to debate. I think some of the members of the Enquiry are qualified to debate philosophy. I must admit I am having trouble doing it myself, but that isn't our job here.

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DR. BUTT: Could I add one thing. I took the liberty of reading a lengthy paragraph of a social worker and I have a quote from her. I should say about [illegible] and the only fear I would particularly think would

support the idea that the person has the right to decide how he is going to spend his money himself and that it is his responsibility to do it." In all fairness to the rest she said "I would say it is one possible way. I wouldn't say I would support it". That is the social worker's answer. I think in fairness that there are two sides to the coin. I believe you feel it is the same thing as the baby bonus?

DR. McGILLIVRAY: Mr. Chairman, may I ask one question: If a citizen is not fit to decide whether or not he will have insurance and how he will use his Social Justice Money, if I may use my term, is he fit to vote? I am not asking anybody to answer that, but I think the Committee should consider this.

THE CHAIRMAN: Any further questions? Do you have any further statement, Doctor?

DR. McGILLIVRAY: No, sir.

THE CHAIRMAN: Thank you very much.

---Whereupon the hearing was adjourned until 10:00 a.m., Tuesday, 21st January, 1964.

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